HEALTH EMERGENCY

Bulletin of Hands Off Our NHS * No.62 * Spring 2006

10 percent or more of NHS jobs in England could face the axe in "sacrifice to market"

Squeezing NHS for profit

THE RECENT wave of redundancies in NHS Hospitals is just the tip of the iceberg of cutbacks to come as ministers deliberately destabilise hospital Trusts and Primary Care Trusts.

Over 100,000 jobs could go in a process that has been called "creative destruction" – many of them nurses and professional staff vital for effective and quality patient care.

As *Health Emergency* goes to press (April 12) almost 8,000 redundancies have been announced in English hospitals as Trust bosses wrestle with multi-million deficits carried over from last year.

But tens of thousands more cutbacks are on the way throughout England, driven by government policies, which aim to scale down public sector health care to make more space for a new private sector.

- Many of the most indebted Trusts have yet to announce their plans to axe jobs and scale down services
- But the cutbacks will not be restricted to indebted Trusts: many that were not overspent last year will also have to make cuts to balance the books in 2006-7
- Many PCTs are also facing massive deficits, driving a reduction in referrals to hospital and forcing many to contemplate scaling down or hiving off the services they provide
- The government's six "priorities" for PCTs omit care for older people and mental health – meaning that these services will face more cuts and job losses not yet announced

Paul Box/reportdigital.co.uk

Campaigns against hospital cuts all over the country are showing that ministers are out of step, and that most local patients given a choice choose NHS – and not the private sector

- A new round of cuts is being driven by the policy of "top-slicing" up to 3% of Primary Care Trust budgets this year to create a reserve to cover deficits: this means cutbacks of £400m in London alone.
- The forced reorganisation and merger of PCTs is predicted to axe at least 3,500 jobs:
- More jobs are certain to be axed in "reorganisation" and rationalisation of hospitals, including up to 1,200 jobs in the merger of Nottingham City Hospital and the Queen's Medical Centre
- The controversial new system of "payment by results" will force hospitals and departments all over England to slash their costs (staff) or close down, while tens of millions of funding is diverted OUT of the NHS and in to new "independent sector treatment centres" (ISTCs).

London Health Emergency's Information Director Dr John Lister said:

"These job cuts and closures are no accident. This is a man-made and avoidable crisis.

"A £1 billion shortfall – equivalent to just a few days' health care spending – has been used as a lever to force through drastic changes which will have a massive impact on patient care.

"A new market system is being created to make room for a new private sector that will carve out a growing share of the NHS budget.

"This is a triumph of ideology over evidence, and it is generating not productivity but an increase in bureaucracy in the NHS while guaranteeing profit margins for private treatment centres."

Is French the only language ministers understand?

SO FAR the trade union response to the cutbacks in jobs and services has been low-key. Some local branches appear to lack the confidence or the organised strength to fight back: others appear to be banking on hopes of battening down the hatches and weathering the current round of redundancies.

But with NHS managers increasingly driven to desperate measures, there is a real danger that any sign of weakness will simply flag up a vulnerable sector of staff for another hit.

Meanwhile across the channel, millions of French trade unionists, taking repeated official and unofficial action alongside students and young people, have forced back a major piece of legislation stripping away the rights of younger workers – and inflicted a humiliating blow against the right wing government.

While French workers celebrate their famous victory, so far the scorecard for British NHS unions reads "Hewitt and Blair 8,000: health trade unions nil."

Without any resistance to cutbacks from the workers most directly affected it is very difficult for campaigners, community groups and other union activists to defend the threatened jobs and services.

Campaigns like Keep Our NHS Public, which seek to link up all those fighting cuts and privatisation, desperately need to feel the active engagement of the health unions.

With the pace of Blair's "reforms", it could only be a matter of months before the privatisation process gains a momentum that makes it unstoppable.

Only the unions can prevent that happening and offer a focus for a fightback to defend the basic principles of the NHS against a full-blown market-style policy.

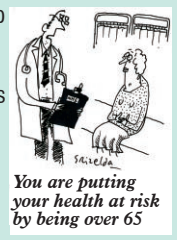
LHE slams move to "cap" GP referrals

London Health Emergency has slammed a government imposed scheme to ration numbers of patients referred by GPs to hospital consultants as a "panic measure".

News of the cash-led rationing scheme, which would process each GP referral through a "referral management centre" broke with the publication of a leaked document in *The Times*, in which managers discussed measures to restrict Londoners to the lowest 10% of hospital referral rates anywhere in England.

The whole exercise appears to be aiming to cut £25m from an NHS London budget of £10 billion.

The London-wide clampdown on GP referrals and consultant to consultant referrals has been imposed by top civil servant John Bacon.



You are putting your health at risk by being over 65

But London is far and away Europe's biggest city, with a population equal to Scotland and Wales combined: it has to cope with a huge pool of poverty and deprivation. NHS bosses offer no evidence to show it would be appropriate to restrict Londoners to the lowest levels of hospital treatment in the country.

One of the areas picked out for heavy manners is Hammersmith Hospitals – a trust with one of the biggest London deficits, £35 million. LHE's Geoff Martin said:

"This is direct management interference in clinical decisions and it makes a mockery of the government's so-called 'Choice Agenda' for the NHS.

"These are panic measures aimed at clawing back a tiny fraction of the NHS deficit of well over £1 billion. But they will also restrict patients' access to care – and create an even deeper financial problem for hospital Trusts which are struggling for survival.

"GPs will be under financial pressure not to make consultant referrals and the principle of a consultant second-opinion, part of the fabric of the NHS, will be slung out of the window.

"This is crisis management, imposed by accountants and bureaucrats regardless of the impact on patient care, and will have severe consequences for patients who slip through the net."

● The Curse of PFI – centre pages ● Independent Sector Profit Centres – page 6 ● United Health Fact sheet – 5

Fattening up the fat cats

Pay for senior NHS managers jumped by 7% last year, while directors of Foundation Trusts pocketed an extra 10% – compared to an average rise in earnings of just 4.1%. The top NHS Trust chief executives are now scooping up £200,000 or more.

Meanwhile chairs of acute hospital Trust Boards have been fuming that their pay – currently £21,882 for a 3-day week – has been outstripped by chairs of PCTs, who can now stroll off with a tidy £30-£40,000 for the same effort.

The real quangocrats will be the chairs of the newly merged Strategic Health Authorities who will trouser sums up to a cool £60k, provided they pass a psychometric test (presumably to prove they are both psycho and understand the metric system).

"Nurse, it's time for my cash injection"

Does Hewitt know her left from her right any more?

Where has all the money gone?

Ministers constantly respond to questions on the financial crisis by insisting that NHS spending has doubled since 1997. It has. But this does not tell the whole story: when the Labour government took over in 1997, many Trusts were facing deficits which had been "managed" by one-off financial measures year by year.

And for the first three years of the new government, in which Gordon Brown upheld Tory cash limits, and NHS spending only rose marginally against inflation, this same situation continued.

Some Trusts have carried forward deficits in one form or another ever since. Others have been better resourced.

When the NHS Plan of 2000 was followed up by the new government policy of substantial real terms increases year on year in NHS spending from 2001, every additional £1 million came with strings attached – in the form of at least an additional £1m worth of new targets, including reduced waiting lists and waiting times, improved performance in A&E, etc.

The NHS employers' body the NHS Confederation has argued that almost three quarters (73 percent) of the additional money in 2004/5 was allocated to services that had previously been "chronically underfunded".

The Confed cites the Wanless report into NHS funding which calculated the cumulative under-spend between 1972 and 1998 at £220 billion in 1998 prices, or £267 billion relative to EU average spending on an income-weighted basis.

20 percent of the extra money has been spent on providing additional services.

The NHS Confederation also notes a substantial increase in the numbers of staff across the health service, with 10 percent more GPs, 20 percent more nurses, 22 percent more health professionals, and 30 percent more consultants than 1999: in all there were an extra 230,000 staff in post in 2005.

Pay settlements for GPs and consultants and the European Working Time Directive have substantially increased costs for PCTs and NHS Trusts, while Agenda for Change has increased the overall pay bill across all sections of staff.

External supplies and services from the private sector have gone up in price even more rapidly.

The NHS Confederation points out that the drug bill has increased by 46 percent since 2000, to £8 billion, pushed upwards by costly new drugs (like Herceptin), while PFI schemes are forcing up overhead costs and taking an increased share of NHS Trusts' income, averaging 11 percent of their total budget.

Costs of the new IT systems needed to implement the government's controversial "choice" agenda are rocketing upwards, while the introduction of the new system has been postponed yet again.

Office of National Statistics figures show that in 1995, for every £1 spent on NHS staff, 71p was spent on goods and services from the private sector: but by 2003, for every £1 spent on staff, £1.14 was spent on private sector goods and services. The private sector has been forcing up NHS costs, while NHS staff are working ever harder to meet tough performance targets.

To make matters worse, the constant national level reorganisation of the NHS (the current shake-up – involving the merger and restructuring of Primary Care Trusts – is the fifth major change since 1997) has consumed management time and resources, and confused and demoralised staff.

The preparation for the new, competitive system of "payment by results" in April has further increased administrative costs for Trusts, and left some sections of NHS departments under-used and less efficient.

To avoid incurring losses under the new financial regime, a Trust with prices above the reference cost would have either to find ways of slashing back its costs (predominantly through cuts in staffing and skill mix) or decide to pull out, and close down services which jeopardise the viability of the Trust as a whole.

New rules introduced by the Treasury last year have attempted to prevent NHS Trusts and PCTs from resorting to the age-old trick of switching money from their capital accounts (to pay for new buildings, repairs and new equipment) to revenue to avert larger deficits: the result has been larger deficits showing up on balance sheets.

Throughout much of the last financial year it was clear that Trusts and PCTs were running up large and unbridgeable deficits: but this was the run-in towards the 2005 General Election, and there was little if any government pressure to balance the books at the expense of politically embarrassing cuts in services.

As a result, much larger debts than usual were rolled over into the 2005-6 financial year, and this is the background to the cash crisis: the NHS is receiving more money than ever, but is facing much bigger cuts than at any time in its history.

Damaging as they were, the first round of cuts, job losses and "efficiencies" proposed by trusts fell far short of the sums needed convincingly to balance the books or secure recurrent balance for future years.

That's why a round of phony cuts has been followed by a fresh round of real, painful cuts in jobs and services, affecting not only Trusts with large carried over debts but also other Trusts seeking savings to balance the books this year.

Squeezing A&E care

If you are going to need emergency treatment this year, get to hospital as soon as possible: under a bizarre new formula designed to reduce demand for emergency care, Trusts will be paid only half the normal tariff rate for treating "extra" patients admitted as emergencies above the levels of 2005-6 – so when the money runs out it will be hard to get in.

And PCTs are urged to limit elective referrals to a maximum of 3% above 2005-6 levels.

Both these instructions from the Department of Health clearly ride roughshod over the notion of patient choice, and place financial concerns above patient care.

Check-out

£3m has been set aside to pay teams of private sector accountants and management consultants to step in as "turnaround teams" in floundering NHS Trusts.

No audit has yet shown that this represents value for money.

Did you know?

Since 1999 the NHS has recruited 230,000 extra staff, including:

- **23,000 doctors**
- **67,900 nursing staff**
- **26,500 therapists and professional staff**
- **71,700 clinical support staff**

The consultants' contract cost £140m more than projected, and the GP contract £250m. The Department of Health estimates the additional cost of Agenda for Change pay settlements for 1.3 million health workers at £1.1 billion in 2005-6.

Drugs swallow up cash

King's Fund economist John Appleby has calculated that just 13% of the additional money allocated to the NHS in 2005-6 was available to spend on developments and improved services.

Half of the £3.6 billion was absorbed by higher pay, while 17% went on higher drug prices and the prescribing of more costly drugs approved by the National Institute for Clinical Excellence.

Another 20% was consumed by clinical negligence costs, capital costs and other non-pay inflation, leaving just £470m 'extra' for the NHS.

The equivalent figure this year seems likely to be 28% of the new money – equivalent to £1.26 billion.

DoH figures show that "underlying pay, price and other cost pressures" will gobble up £3.8bn of the £5.4bn extra funding for PCTs in 2006-7.

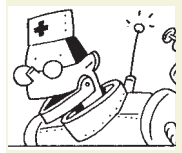
The tariff for payment by results is increased by just 1.5% in real terms, and NHS Trusts are required to generate a hefty 2.5% "efficiency savings" while simultaneously paying back any borrowing from last year, breaking even this year, and generating a surplus on top.

Patricia Hewitt urges anyone still standing after achieving all that to shove a broom up their arse and sweep the floor.

DRIP FEED

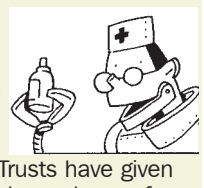
IT boffins need a boot up...

THE GOVERNMENT is headed for another massive IT fiasco as its £6.2 billion project to computerise the NHS runs into crisis, according to 20 leading academics.



The scheme is the world's biggest civil IT scheme, and it is supposed to establish an electronic patient record for each NHS patient.

But the contracts for the project have been given to three different companies (Accenture, BT and Fujitsu), each of which has run into difficulties, while impatient doctors and NHS Trusts have given up on a scheme begun four years ago, and installed their own solutions.



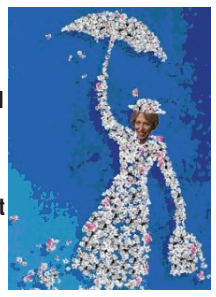
Don't hold your breath waiting for choose and book.

No logic in Logistics hive-off

Ministers are forging ahead with their ideologically-driven privatisation of the NHS Logistics Authority, handing the contract to a consortium that includes Novation, a US-based medical supplies firm facing investigation over alleged over-charging for services to the federally-funded Medicare programme.

NHS Logistics had a turnover of £777m last year, supplying food and medicines to hospitals but is run on a non-profit basis, and even paid a rebate of £3m to the NHS. There is no record of any private companies surrendering any share of their profit.

Oh, no, minister …



Ministers have been making promises far beyond the capacity of the NHS budget to deliver, according to the *Health Service Journal*.

The *HSJ* (March 30) has identified a £2 billion gap this year between the £12 billion Department of Health central budget and the cost of pledges made by Hewitt and her gang to improve services.

By November the *HSJ* reports, the DoH was ordering staff to "disregard promises made by ministers".

Fair enough: that's what most of us do all the time.

White Paper – a blank cheque for privatisation

THE government's latest White Paper *Our health, our care our say*, aims to drive forward the privatisation agenda into community health services – and pays only lip-service to the choices patients actually make.

Despite the hype and rigmarole of the so-called 'Citizens Summit' in Birmingham, at which obedient coach-loads of punters were plied with vol-au-vents, sausage rolls and speeches from Patricia Hewitt, the White Paper rejects the proposal that came top of the list, and largely ignores the second and third priorities as well.

75% of those responding had put as their top priority a "regular health check or MOT for everyone": that has been ruled out by ministers.

And while over 60% wanted a focus on mental well-being, the platitudes on this in the White Paper run flatly counter to the cutbacks currently hitting mental health services across the country.

Indeed ministers issuing six priorities for Primary Health Trusts omitted both mental health and care for older people from the list – ensuring there will be even more cuts to come.

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Over 40% of responses wanted a priority focus on help for carers the regime of cutbacks in both hospital and community health care is dumping ever-increasing burdens on to carers, with little evidence that either the NHS or social services have the resources or the political will to offer adequate support.

Instead the endless rhetoric about "care closer to home" is consistently wheeled out as a pretext to close hospital facilities, with little or no focus on ensuring that alternative provision is put in place to support patients and carers.

Interestingly the proposal for a full-scale mixed economy of primary and community health care – allowing "other organisations to set up local health centres" – came bottom of the Citizens' Summit list with around 6% support: yet this is the area where ministers have been most eagerly active. That is because it fits completely with the general drive towards private sector involvement.

But it is Chapter 7 of the White Paper "Ensuring our reforms put people in control" that is the real business end of the proposals.

Here the language is much more straightforward, revolving around the notion of "choice" as the driver of a new competitive market:

"Choice means people will increasingly determine the services they want, and where. providers that offer these services will thrive; those that do not won't."

This emphasis on "listening" to the view of local people came at the same time as a classically insensitive "consultation" exercise on the reorganisation of PCTs and SHAs in which it was quite obvious that patients' views and any notion of accountability were a complete irrelevance.

Having scrapped the Community Health Councils which in many areas were a strong focus for patient views, ministers are tinkering again with the toothless and largely pointless Patient Forums.

But in the end there is only one type of patient voice they want to hear, and that is individuals calling for more privatisation: "local triggers" will be established that can oblige a PCT to put any service out to tender for "any willing provider": there is, predictably, no equivalent "trigger" for those wanting a lousy privatised service brought back in house.

PCTs are urged along the road of divesting themselves of direct provision of services, and to see themselves as commissioners from a range of public and private providers.

The forced merger of PCTs helpfully merges many of their direct services into larger units, which will make some of them more attractive for private sector bids.

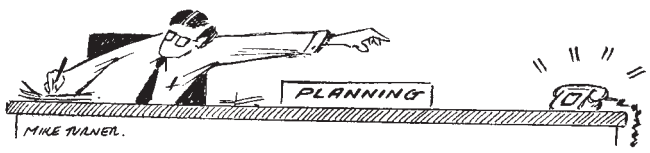
Within the PCT budgets, GP practices are urged to take on Practice Based Commissioning, with a single aim in view – to reduce the use of emergency and non-emergency hospital services and thus "free up money to do more for people with long-term conditions".

A key theme in the process of commissioning will be "to secure the participation of the independent and voluntary sectors".

But since that appears to be the political mission of New Labour reforms there is no real surprise or change there: the White Paper simply reminds us that no sector of the NHS is safe from the grasp

Epsom and St Helier Anatomy of a health planning fiasco

Geoff Martin



Back in 1999 health chiefs in South West London pressed on with a plan to merge St Helier Hospital in Carshalton with Epsom Hospital in Surrey.

This was a hospital merger that, even in the long history of weird health plans, was bizarre in the extreme.

St Helier is in the northern part of the London Borough of Sutton, located bang smack in the middle of the sprawling LCC council estate that shares its name. Epsom Hospital, in leafy surrey, serves a rapidly growing catchment population stretching deep into the stockbroker belt towards Guildford.

As well as bringing together two hospitals in completely different geographical areas, and cutting across all planning boundaries and health authority jurisdictions, there was also the small matter that the buildings at St Helier had been condemned as unfit for human habitation as far back as the mid 1970s.

At the time of the merger LHE and UNISON condemned the plans as "a shotgun marriage that would only make sense if the long term objective is to close one of the two hospital sites."

Naturally, health chiefs denied this, but within months of the merger taking effect a plan was unveiled to begin decanting the core front line services at Epsom like A&E, maternity and HDU and relocating at St Helier.

We mounted a fierce campaign of opposition and we won – and we even had the then Chief Executive's head paraded on a spike, to the popular acclaim of the voting public. It was a temporary reprieve.

The bureaucrats went back to the drawing board and, although we chewed up and spat out yet another Chief Exec in the process, they surfaced with the cuddly sounding "Better Healthcare Closer to Home."

This closely aped the original, discredited single site plan, but left the choice of the hospital location open to speculation and even offered a range of mad-cap locations including just about everywhere other than Benidorm on the Costa Blanca.

A laughable public consultation was set up and a gaggle of local MPs predictably engaged in a turf war that enabled the health bosses to play Epsom off against the London Borough of Sutton.

Although the consultation found that the vast majority of local people supported LHE and the unions and wanted services developed at both Epsom and St Helier, the Trust went all Stalinist, and in a move that Orwell would have loved claimed that what people really wanted was a new 'critical care unit' on the Sutton Hospital site – probably the least favoured option of the lot.

And so they began to sling vast sums of public money at developing the Sutton site option. In the meantime they tried to smuggle through a plan that would have seen the elective orthopaedic centre at Epsom (SWLEOC) privatised wholesale and handed over to a gang of American venture capitalists.

An audacious LHE-led counterattack ambushed the Trust Board on their own manor and sent them running for cover. The plan has now been shelved.

And then came the biggest bombshell of the lot. Behind the scenes a Blairite mafia from Mitcham had put the squeeze on the PM, arguing that Sutton was too far away from their manor and that the single hospital should be located at St Helier … and fuck the consequences for anyone south of North Cheam.

In a classic act of political chicanery Hewitt stepped in, pulled the Sutton plan, and instructed the Trust to start planning a new PFI hospital at St Helier.

Millions have been wasted, the scheme's project manager has been sent into some sort of managerial asylum in Bristol, and the rest of the Trust's top brass have been holed below the waterline.

But even that's not the end of the story. As soon as the Christmas decorations were taken down, the Trust wheeled out two consultants to argue that Epsom is dangerously short of consultant cover and that critical care services should be axed sharpish and transferred to the crumbling, overcrowded buildings at St Helier … the exact same plan that was binned 7 years ago.

In early April hospital bosses at the Trust announced that they are looking to speed up the closure of key front line services on the Epsom Hospital site in Surrey as they struggle to claw back a soaring cash deficit.

Services due to be axed at the strategically important Epsom Hospital site close to the M25 include:

- Paediatric accident and emergency – downgraded to minor injuries
- In-patient paediatric beds
- The main maternity unit
- All trauma surgery

The Trust are laying down plans for an immediate £10 million of cuts this year – 5% of their non-capital expenditure – and have not ruled out redundancies.

However, they admit that they cannot forecast the consequences of the new funding formula, and they also have failed to agree contracts for this year with their cash-strapped local Primary Care Trusts. Adverse movement on these income streams could see the cash gap rise to £67 million over the next few years.

The scale of the looming financial crisis at Epsom and St Helier, a Trust which balanced its books in 2005-6, exposes the chaos of the government's new funding formula for the NHS.

It will rip a hole in services covering a large area of the South East. The knock-on effect will ripple out from south London all the way down to Sussex.

Crisp's final crunch

Four days before the end of month 11 of 2005-6 leading DoH bureaucrat Duncan Selbie issued a diktat to finance chiefs instructing them to take "immediate action" to tackle the worsening NHS financial situation and to sign off plans to "materially improve the position for months 11 and 12".

Local managers were warned that Sir Nigel Crisp would personally be checking on their progress.

At the same time bungling DoH apparatchiks were recalling the tariff of fees they had sent out for the roll-out of payment by results because errors had been detected at the last minute. At the end of February Trusts and PCTs were left in the dark on how much they would receive or pay for treatment beginning in April.

Days later Sir Nigel had gone, "retired" at 54 with just a peerage, a £3m pension pot and a sinecure promoting market-style health reforms in Africa to console him: if that was his reward for failure, those trying to clear up the mess he left behind will be convinced he was the lucky one.

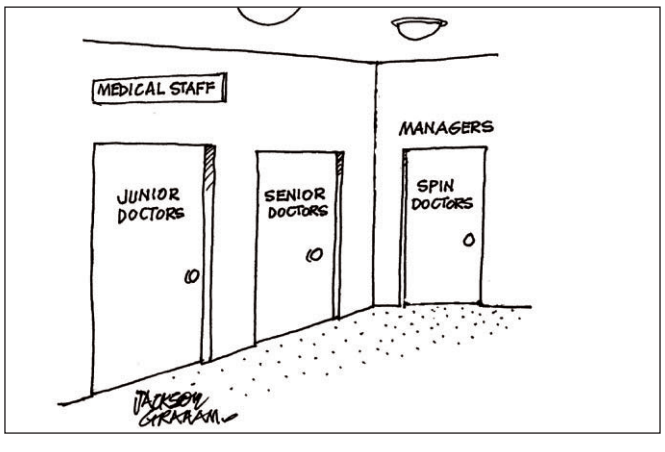
HCA cashes in on UCLH crisis

The biggest US health care corporation has got its feet under the table of the NHS in a new contract with the cash-strapped University College London Hospital foundation trust.

Hospital Corporation of America has formed a joint venture with UCLH to provide an international cancer centre that will boost the hospital's private patient income.

HCA runs more than 270 hospitals and surgical centres worldwide, including six private hospitals in London.

It will now take over private patient operations on the 15th floor of the new UCLH tower in London's Euston Road to provide a specialist blood and bone cancer centre aimed at international and UK patients.



Trusts across the country struggle to deal with

The curse of PFI

Totting up the real cost of PFI

While private sector companies crack open the champagne at the prospect of decades of guaranteed profits and inflation-proof income streams, many NHS Trusts are struggling to pay the bills in disastrous first wave PFI schemes.

The best known example is the £93m Queen Elizabeth Hospital, Woolwich, just over the river from the new Bart's & London project, which has now been deemed technically bankrupt, with an annual deficit that threatens to reach £100m by 2008-9 if its PFI debts are not restructured.

PFI – with annual payments of £20m including rent and support services – added £9m a year to the costs of the hospital compared with a publicly-funded equivalent. The deal could only have been done with the promise of government subsidies to bridge this gap – but these subsidies ("smoothing payments") are now being withdrawn leaving Trusts like QEH in the lurch – closing beds and axing jobs.

But the catch is that if the Trust goes bust the PFI consortium will still scoop a massive profit – and pocket a £140m bond underwritten by the government.

In central London, one of the country's newest PFI hospitals, the £420m University College Hospital – now a Foundation Trust – is closing beds and axeing services as it wrestles with a deficit estimated as high as £40m, with a team of "turnaround" KPMG accountants and management consultants in constant attendance at a thumping £1,000 per person per day.

■ **Bromley's new PFI Hospital was also due to be subsidised by "smoothing payments" that are being phased out, leaving the Trust stuck with a £15m deficit as the financial year gronds to a close.**

■ **Just outside London, one of the early PFI schemes, Dartford's Darent Valley Hospital, faces a loss of income under the payment by results system, and closed three wards and cancelled 200 operations in February and March as managers slammed the brakes on to slow spending.**

London's £420m PFI-funded UCLH, facing a deficit of up to £40million, has now hived off a whole floor to US hospital giant HCA

Who will foot the bill as full impact hits Trusts?

£2 billion PFI hospital schemes get go-ahead

IN THE MIDST of a major round of economies, cuts and job losses ministers have rubber-stamped the schemes for three mammoth hospital projects costing a total of well over £2 billion, to be financed under the Private Finance Initiative (PFI).

London's East End, Birmingham and St Helens in Lancashire will each see new hospitals built at huge cost despite mounting evidence of the problems faced by PFI-funded hospitals, which have begun slashing back on staff and closing beds and services as they wrestle with inflated overhead costs.

The first big announcement came in March when, after prolonged delays and a top-level review, Patricia Hewitt finally ended the constipated silence over the future of the £1.9 billion plan to rebuild Barts and the London hospitals – and gave the nod to a plan that nobody wanted.

250 beds – 20 percent of the planned capacity – are to be axed, with three floors of the new buildings to be left empty to wrestle down the capital cost of the scheme by £160 million.

So the new mega-hospitals will have fewer beds than they do now, explicitly breaching the assurance of previous Health Secretary Alan Milburn that any second-wave PFI hospital would have to have at least as many if not more beds than the services it replaced.

The "unitary charge" to be paid to the PFI consortium, Skanska Innisfree, will be reduced by £20m a year – but remains a staggering £96m a year, index-linked over 35 years – equivalent to a massive 20 percent of the Trust's turnover last year.

Even if we assume the rent element will also be reduced by the same proportion, this means payments of at least £55m a year – 11.4 percent of the Trust's total income. This leaves the Trust no leeway to deal with future financial pressures.

And these payments will have to be taken from other parts of the East London health economy, plundering budgets for primary care, mental health and community services.

The additional delay while Hewitt piled on the pressure to trim back the project has added an extra £35 million to the overall cost.

The empty floors will stand as a vivid monument to the folly of PFI, while the bed cuts come despite the insistence by consultants that the full plan was absolutely essential to deliver the planned mix of services to the people of the City and East End.

Their anger and frustration was summed up when at the end of last year 1,000 doctors signed an appeal for the long-delayed project to go ahead.

New hospital buildings are urgently needed to replace the crumbling Royal London, but it is also important to deliver the cancer care, cardiac services and paediatric care that East London's population have a right to expect: that's why the services currently provided on the Bart's site are vital to the capacity of the Trust.

The new University Hospital for Birmingham has rocketed again in cost from a last estimate of £521m to a staggering £697m when finally signed off by health minister Rosie Winterton in April 2006 – more than double the projected cost of the scheme when it was put out to tender in the Official Journal of the EU four years ago.

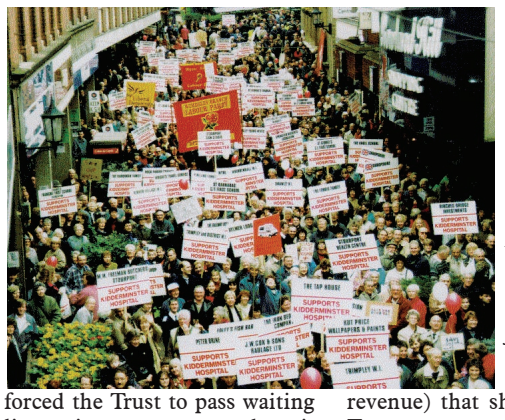
Press statements have avoided the thorny question of how much this will cost the Trust over the 35 years of the PFI contract – and Birmingham is the first and only major hospital project to have a PFI scheme covering only the building – and not also including support services.

The new hospital for St Helens will be a £338m hospital in Whiston and a new diagnostic unit.

Worcestershire faces new cuts

In Worcestershire the £100m PFI hospital that famously triggered the closure of A&E and in-patient acute beds at Kidderminster Hospital – and cost the local Labour MP his seat when he supported the closure – has remained mired in crisis ever since.

Lacking beds, space and cash the Worcestershire Acute Hospitals Trust is staring down the barrel of a £31m deficit on a £250m turnover. Chief Executive John Rostill is quite open in pointing the finger at the added costs of PFI as the root of the historic debt, but the cash pressures have been compounded by the lack of beds, which has forced the Trust to pass waiting list patients over to costly private hospitals. Now a new private sector treatment centre is operating out of Kidderminster, and scooping up patients (and revenue) that should go to the Trust.



Thousands marched to defend Kidderminster hospital: now the PFI hospital at Worcester is facing cuts as well

700 jobs are now to be axed, along with beds and services as the Trust tries to balance the books.

PFI round-up

VIRTUALLY EVERY PFI hospital is now in financial difficulty, or about to be plunged into problems from April 2006 when the new system of "payment by results" comes in, paying Trusts only a fixed price for each item of treatment they deliver, regardless of the inflated overhead costs faced by PFI hospitals.

Double trouble

In the North East the merged County Durham and Darlington Trust, spanning two PFI Hospitals in Durham and Bishop Auckland, is shedding 700 jobs and axing services in a bid to cut spending by £40m.

Rebuffed or reprieved?

THE £1 BILLION PFI scheme in West London (Paddington Health Campus), axed at the end of last year, with an affordability gap of £40m a year, is so far the only big NHS project to have bitten the dust completely, although other schemes around the country face drastic reductions .

Others, including a £760m scheme in Hewitt's own constituency of Leicester, and projects in Stoke on Trent and Bristol could well also face the axe.

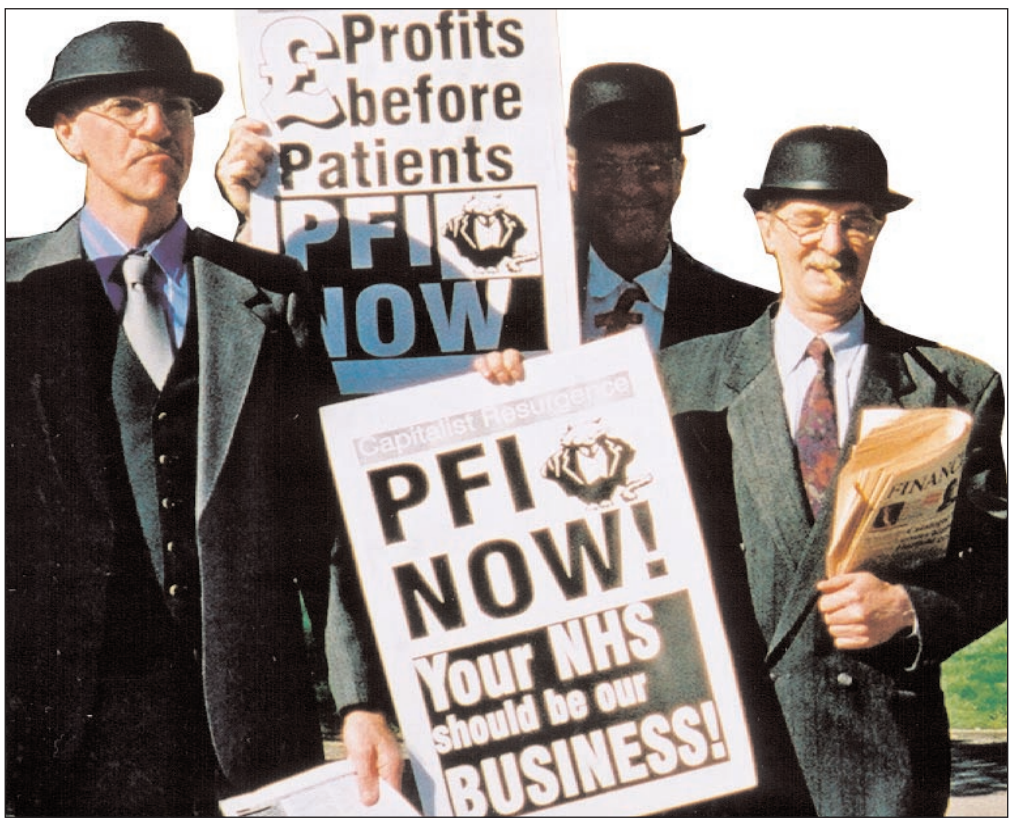
Sky-high returns

PFI INVESTORS are pocketing returns of 14-15% on their holdings, and fuelling a profitable "secondary market" in established PFI contracts – and even the Treasury has noticed.

"Simply put, we think these returns are too high," says the head of its Private Finance Unit.

The private sector carries no real risk, but collects huge rewards.

When Hewitt called in the Barts & London scheme for review it was revealed that even if the project was cancelled, Skanska the PFI "partners" would laugh all the way to the bank with a monster £100m pay-off, having delivered nothing but frustration to local people.



PFI: a figleaf for Brown's refusal to invest in NHS

TIME AND AGAIN health workers, doctors and local people have been cruelly misled into believing that PFI enables the NHS to do the impossible – and deliver state of the art new hospital facilities at a price that fits NHS budgets while guaranteeing healthy profits for the private sector, despite the desperate lack of public sector capital.

But PFI has been the fig leaf behind which the government has hidden its refusal to invest in the long term future of the NHS, with just 4% of the capital for new hospital projects coming from the Treasury.

And throughout the 12-year process PFI has been costing millions – for management consultants, accountants, lawyers, and soaked up endless NHS management time.

One of the reasons for ministers getting cold feet over signing off the new round of PFI hospitals is not so much the fears over the future affordability of massive projects, but a result of the accelerating pace of privatisation of health care under New Labour.

On the one hand their plans to float off all major NHS Trusts as free-standing 'Foundation Trusts' accountable only to

Monitor (the – largely privatised – independent regulator) will mean that fewer hospitals will be able to negotiate PFI deals, which all rely upon the underlying guarantee that the Secretary of State for Health will be obliged to step in and compensate the PFI consortium if a Trust goes seriously bust.

If the Secretary if State is no longer responsible for the hospital, there is no basis for this guarantee, and the PFI consortium could be exposed to risk.

But on the other hand ministers have become ever more obsessed with the notion of the NHS acting not as a provider of services but as a continental-style insurance fund, purchasing ("commissioning") health services from a range of (increasingly private or privatised) providers.

On this model it makes no sense to keep forking out large sums to rent buildings for the NHS to deliver care, when they could simply turn to the private sector to deliver these services, building and maintaining their own "Treatment Centres".

Admittedly this would leave huge gaps in care, since the private sector has shown no interest in delivering much of the bread and butter work of the NHS – emergencies, chronic conditions, and complex cases.

However ministers appear to have abandoned all but the most rhetorical commitment to planning or equitable access to care as they plunge eagerly into creating a barely regulated market system that seems destined to bankrupt a substantial number of NHS hospitals and even more local specialist units.

The answer to all this is not PFI, which threatens decades of financial dislocation to health care, but to demand the government scraps the PFI policy as a failure, and steps in to loan the cash to build the new hospitals that we all agree are needed.

Triple whammy for Norfolk & Norwich

The first big PFI hospital in England, the £220m Norfolk & Norwich hospital, has also found itself caught in the wheels of a growing crisis: its procedure costs are inflated by PFI payments for the new building and equipment, meaning that it faces the loss of £5.2m a year under payment by results.

It also stands to lose two thirds, and then all of the £3.8m a year "smoothing payment" from the government towards the £35m unitary charge payable to the consortium, designed to make the PFI deal less unaffordable.

And with NHS inflation running far ahead of the uplift in tariff this year, the combined picture is one of a £22m shortfall – forcing the threat of 700 job losses.

Wakefield PFI would axe 40% of beds

The Mid Yorkshire Hospitals PFI scheme – last costed at £300 million before the final, detailed negotiations begin with the chosen consortium, has already identified an "affordability gap" of £11.4 million per year, and begun to reduce bed numbers and the size of the new hospitals to save money.

The Trust was named as one of the 18 with the most intractable financial problems in England at the beginning of the year.

A first review by management consultants Secta proposed to lop 100 beds off the plans set out in the Hospital Development Project, leaving the Trust 238 beds short of the total it had in 2004. But last year a "rescoping exercise" went back and slashed even these proposals, cutting a massive 560 beds (40%) from the 2004 totals – again purely to contain costs, and without any evidence that suitable alternative facilities would be available to care for patients outside of the scaled-down Trust.

Wakefield PFI: now you see it … now you don't

The scheme's proposed £50m hospital to replace the General Infirmary in neighbouring Pontefract will now have only a handful of inpatient beds – a few for medical assessment and observation, and a few more for rehabilitation.

In other words Pontefract would no longer have a general hospital but a glorified outpatient, diagnostics and day surgery unit: anyone requiring in-patient treatment, including all but the least complicated maternity cases, would have to travel to Wakefield.

UnitedHealth

Keep Our NHS Public fact sheet

Not a clean bill of health

What is UnitedHealth?

The UnitedHealth Group is one of the largest health sector corporations in the world. It is based in the United States.

Its core business is the sale of a variety of health care products and services, in particular health services and health insurance products.

It consists of several separate businesses, each of which focus on a particular type of product or niche within the health care market.

How big is it?

UnitedHealth is big. In 2004 it ranked first in the US in net sales of healthcare insurance. Furthermore, the company is growing through various acquisitions and mergers within the United States and by breaking into public health services in Europe.

The aim of UnitedHealth – profits

The aim is to generate wealth for its executive board and senior managers, and shareholders.

UnitedHealth's recent Annual Reports show the company to be achieving record net earnings of $11.3 billion. The chief executive of UnitedHealth, William McGuire, earns a total annual income of $124.8 million in 2004.

How does it make its profits?

In the US, health care is big business – $1,500 billion a year!

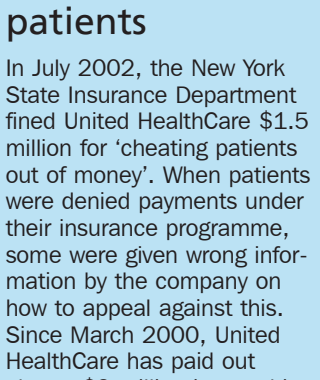
Academic research shows that companies like UnitedHealth make profits by:

■ 'cherry picking' or 'cream skimming' – companies like UnitedHealth select the profitable treatments and patients by placing access restrictions on the services they offer. Wherever possible, those who are elderly, frail or at high risk of chronic illness are excluded from insurance or comprehensive health cover.

■ 'charging for risk' – companies like UnitedHealth expect individuals with high health risks to pay higher insurance premiums, have a more limited range of benefits, or have to pay for a higher proportion of the costs of health care through charges or 'co-payments'.

■ 'over-servicing' – companies like UnitedHealth often maximise income by providing unnecessary treatments.

■ 'reducing quality and staffing' – companies like UnitedHealth maximise income and profits by lowering the quality and cost of health care as much as possible. For example, they may close local services, reduce



the numbers of staff employed and use cheaper and less qualified staff.

■ 'denial of care' – companies like UnitedHealth protect their profit margins in the United States by simply denying care if payments can't be met – the risk for the financing of health care in a commercialised health care market tends to fall on individuals and their families.

UnitedHealth also makes its profits from defrauding government funds and patients

In July 2002, the New York State Insurance Department fined United HealthCare $1.5 million for 'cheating patients out of money'. When patients were denied payments under their insurance programme, some were given wrong information by the company on how to appeal against this. Since March 2000, United HealthCare has paid out almost $2 million in penalties in nine different US states for a variety of offences.

In August 2004, United HealthCare Insurance Co. agreed to settle civil Medicare fraud charges with the US Attorney for $9.7 million.

The government claimed that United HealthCare had inflated its cost reimbursements well above its actual expenditure under the Medicare program in order to obtain higher reimbursement and greater performance incentive payments.

In December 2004, United HealthCare Insurance Co. again had to pay $3.5 million to settle charges that it defrauded the US Medicare programme.

The settlement related to charges that United HealthCare knowingly mishandled phone inquiries from Medicare beneficiaries and providers, and then falsely reported performance information to the federal government between 1996 and 2000.

And as recently as December 2005, United HealthCare of Georgia Inc. was asked to pay at least $2.3 million to settle complaints about delayed payments, only a few years after it was fined for similar offences in 2000 and 2002.

How does UnitedHealth gain influence?

In the United States, companies like UnitedHealth spend millions of dollars every year on lobbying activities to ensure that the health care system remains a profitable and commercialised market place. UnitedHealth has been at the forefront of this lobbying, which has included the donation of campaign funds to the Bush campaign in 2004.

In fact the UnitedHealth Group CEO, William McGuire, was among a group known as Bush campaign "Pioneers" for their contribution of $100,000 or more.

Why does UnitedHealth want to run NHS services?

Health care is a multi billion dollar service in the UK and Europe. UnitedHealth and other corporate health providers have been lobbying intensively to create a more open market in health care.

Until now, the NHS in England has mainly been in public ownership and control with a strong commitment to universal and equitable access to health care, the pro-active support of public providers and a rejection of commercialisation.

However, the Blair government has created openings for companies like UnitedHealth to gain entry into the NHS by creating a market in health care.

Entering the UK health care market

In May 2004, UnitedHealth set up a new subsidiary business, UnitedHealth Europe, to explore the market and to lobby for the opportunity to provide health services in Europe.

UnitedHealth Europe is led by a British management team that includes Tony Blair's senior health policy adviser, Simon Stevens, (previously policy advisor to Tony Blair and the former Secretaries of State for Health Frank Dobson and Alan Milburn) and Richard Smith, the former editor of the *British Medical Journal*.

They are now actively seeking to take over the budgets of PCTs and primary care. By controlling the budgets, they control what services patients will get, the employment of staff and their terms and conditions and the flow of funds to shareholders.

www. keepournhspublic.com

Independent sector profit centres

LHE went to last year's Labour Party conference in Brighton to sum up the "smash and grab" raid that is taking place to siphon tens of millions from NHS budgets into the coffers of a parasitic, profit-seeking private sector.

UNDER JOHN Major's Conservative government in 1996-97, after 18 years of Tory rule, the NHS was spending just £200 million a year on buying in treatment from private hospitals and clinics. By 2007, if the Labour government's current proposals are carried through, this will have increased tenfold.

New private hospitals and treatment centres are being built, with more planned, and in some cases existing NHS facilities — built with taxpayers' money, or expensively funded through the Private Finance Initiative at the expense of the NHS — are to be handed over to private sector operators as part of the new arrangements.

One of Patricia Hewitt's very first pronouncements, just hours after taking office claiming to be a "listening Health Secretary", was a new allocation of £3 billion for the purchase of additional treatment from the private sector.

This second major round of tendering for private contracts, which opened last autumn, will be announced in the summer. It could involve purchasing a further 250,000 operations a year, and almost 900,000 outpatient appointments and diagnostic procedures from private sector providers.

Since Alan Milburn's 2000 Concordat with private hospitals to buy in additional short term capacity at times of peak demand (and at inflated prices well above prevailing NHS costs), ministers have adopted the quite explicit objective of expanding private sector provision – precisely to create competition with the NHS.

The most recent tendering documents make no bones about the long term plan:

"A key factor in this Plan is the Independent Sector (IS) Procurement Programme, the purpose of which is to provide additional capacity, expand new ways of working and develop a sustainable IS market. The Plan anticipates that by 2008 the IS will provide an increasing volume and range of both elective procedures and diagnostics tests for NHS patients."

The privatisation of diagnostic services has also begun: private sector MRI scans have also been purchased for NHS patients — again on a long-term, generous contract which allows Alliance Medical Limited, the contractor, to "cherry pick" only the most straightforward and uncomplicated scans, leaving the remainder to the NHS, while collecting full payment despite falling well short of targets for completed scans.

And to make it quite clear that the driving force is privatisation and marketisation rather than expanding capacity, the reduction of waiting lists comes third in the Department of Health's "primary objectives", which are itemised as:

- To help to create a sustainable, VfM [Value for Money], IS market in the provision of elective care to NHS patients;
- To provide more choice for patients and real contestability in elective services;
- To support implementation of the 18-week waiting time target, which comes into effect from December 2008;

The document goes on to assert that the creation of this new competition will somehow "improve productivity and VfM in NHS-run services".

There is no evidence to support this assumption: indeed the first round of Treatment Centre contracts has not yet been completed, with some services yet to come on stream, and there has been no systematic evaluation of the effectiveness or value for money of these projects, which have been centrally decided and funded by ministers and little influenced by local Primary Care Trusts.

The government plan to funnel new money preferentially into the private sector rather that adopt the cheaper and easier policy of expanding NHS provision, has led to a dramatic expansion of commercial medicine.

The private health care sector in Britain has always been a relatively small and marginal operation, feeding off historic NHS waiting lists, poaching NHS staff, shunning emergencies and complex cases, and focusing exclusively on acute (short stay) services: but until recently it was running with only around half of the beds occupied in its (generally very small) hospitals.

Now a massive increase in the numbers of NHS patients being treated in private beds means that the traditional paying patients will only represent just over half of the caseload in private beds, with as many as 45% of private sector operations paid for by the NHS.

This is effectively a huge cash subsidy to force the expansion of a private sector which will inevitably draw on the same pool of human and financial resources as the NHS, but divert a percentage of those resources from patient care to pay dividends to their shareholders.

To foster an expansion of private care to enable it to "develop a sustainable market", ministers have set out to bring in commercial health care companies from around the world, and also offered private hospitals very generous contracts, paying up to 40% above the prevailing costs within the NHS, lavish subsidies towards start-up costs for new private hospitals, and guaranteed payment even for those private providers who treat fewer patients than planned.

The new round of tendering offers slightly less generous subsidies to private hospitals, but promises the extra security of five-year contracts for the winners, while also relaxing the initial restrictions on poaching NHS staff to help run the new private units.

As the Department's own document explains, the new schemes have gone well beyond the notion of expanding NHS capacity, and are now seeking to transfer existing NHS work to private treatment centres. This is the pretext under which the staffing restrictions have been eased:

"Providers will be able to use NHS staff when providing the Services for Schemes where there is transferred activity.

"Where there is transferred activity it is expected that the amount of NHS staff time available to the Provider (as a proportion of the Provider's total staffing requirement) will be approximately equal to the amount of transferred activity as a proportion of total activity to be delivered by the Provider."

However the new proposals also make it easier to employ NHS-trained professional staff even where there is no transfer of activity:

"Providers will only be prohibited from recruiting NHS staff in specialties facing workforce shortages. Work is ongoing to identify any further shortage professions;

"All doctors, nurses and other healthcare professionals (whether or not in shortage professions) will be permitted to use their non-contracted hours to work for Providers, subject to first fulfilling their NHS commitments."

The outcome of these changes seems certain to be a further loss of vital frontline staff from existing NHS hospitals, forcing Trusts to fill more vacancies with high-cost agency staff or cut back on the services they provide – again reducing patient choice.

The harsh reality is that there is no evidence to support the underlying rationale for the government's cultivation of a new, parasitic private sector in British health care. None of the claimed justifications holds water:

Before rushing to commit another £3 billion to a second round of privatisation, the very least Patricia Hewitt and her ministers should do is commission a full and objective, public evaluation of the impact of the first round of treatment centres on the local health economy.

Without evidence that it can deliver any of the promised improvements, the privatisation programme should be halted and the resources invested in staff, facilities and equipment to enable NHS Trusts to meet the 18-week target for waiting times.

'Play or pay' policy lines private wallets

ISTCs are due to treat 200,000 NHS patients this year, but will be paid for this number regardless of how many they actually treat.

Payment by results ensures that all of the cuts and crisis are concentrated in the public sector, which is not allowed to compete for Treatment Centre contracts.

Southampton faces £15m blow

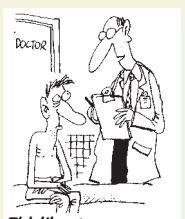
Plans are forging ahead for a new Independent Sector Treatment Centre in the Royal South Hants Hospital in Southampton.

The unit would not only take an existing NHS site, but take an estimated 7,500 patients who would otherwise have been treated in the financially challenged Southampton University Hospitals Trust – along with an estimated £15m in revenue from its departments … and an unknown number of NHS staff.

When Treatment Centres reduce choice

We know that in at least one case – the scheme to bring in specialist eye surgeons and nursing staff from South Africa to deliver routine cataract operations to NHS patients in Oxfordshire – the Treatment Centre project was opposed.

The opposition came not only from consultants and other staff at Oxford's specialist Eye Hospital – the viability of which is seriously undermined by the private sector top slicing a large proportion of its routine work (and revenue) – but also by at least one of the local Primary Care Trusts.



I'd like to see you again next week for the post mortem

Huge pressure was brought to bear to force the scheme through, resulting in resignations from the PCT: but there is no evidence that paying up to 40% more to commission these services privately rather than allowing the NHS to implement its previous plans to deliver waiting times will do anything but undermine NHS efficiency.

Hundreds of operations at the new unit have now been paid for but not carried out. as NHS patients insist on exercising their choice to go to the Oxford Eye Hospital instead.

Similar questions hang over the scheme that is due to slice off 85% of the orthopaedic caseload from the Brighton & Sussex Hospital, and instead purchase £18m of NHS treatment a year from a newly-created private treatment centre.

This will leave the NHS with only the most costly and complex cases and emergency work: there is nothing to suggest that this would be more efficient or better value for money, and plenty of grounds to fear that this specialist unit, too, could be rendered financially non-viable by the treatment centre programme.

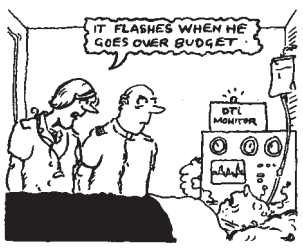
Its closure would not only reduce choice for NHS patients (and create a virtual private sector monopoly) but also force those needing any more complex or urgent treatment to travel many mile to an NHS alternative.

Campaigners have won a stay of execution for the SW London Elective Orthopaedic Centre – see article, page 3

Plum NHS units to go private

The document on the second wave of treatment centres outlines plans to hand over a list of NHS facilities to private sector companise to run for profit:

- **A brand new state of the art NHS Treatment Centre in Birmingham, not even yet open, is to be handed over to private operators,**
- **Also facing privatisation is a specialist unit in the new PFI-financed New Forest hospital in Lymington:**
- **Other modern NHS treatment centres, including Ravenscourt Park Hospital in NW London and the SW London Elective Orthopaedic Centre in Epsom,**



also face the threat of privatisation (for SWLEOC see page 3).

- **In South Yorkshire NHS catheter laboratories in Rotherham and Barnsley could be handed over as part of a cardiology contract:**
- **"Spare surgical capacity" in NHS hospitals in the South West Peninsula could also be made available for private companies carrying out NHS-funded operations;**
- **And a huge renal dialysis contract covering much of the north of England could see dozens of NHS units handed over for private operators to refurbish and run for profit.**

The expansion of the private sector at the expense of the NHS is not an automatic or accidental process: it could not have occurred without government sponsorship.

Private view

A survey of the private sector

Medics critical of ISTCs

A BMA survey of 177 NHS clinical directors has found that just 5% of them thought standards of patient care were much better at private sector-run treatment centres than those in the NHS. Six times as many thought the NHS service had brought more benefits to patients and local health services.

Not one of the clinical directors thought that ISTCs had had a positive impact on their NHS facilities or services – but 42% thought there had been improvements as a result of NHS-run treatment centres.

Three quarters of respondents said they were aware of patients being rejected by private treatment centres, and many cited these centres "cherry picking" of the least complex cases as a problem for local NHS hospitals. This will be even more of a problem under payment by results which assigns a fixed fee per case regardless of complexity.

Royal Colleges have also voiced increasing criticism of the standard of care delivered by ISTCs, not least because the NHS was too often being obliged to "pick up the pieces" after botched operations by inadequately qualified surgeons.

The case of the missing operations

A NEW ISTC in Portsmouth treated less than a fifth of its contracted level of cataract patients in the first three months, leaving the PCT holding a bill for £330,000 for operations that had not been carried out.

Mercury Health blamed a slow response from local GPs for the under-performance on cataracts and other diagnostic tests and orthopaedic surgery: the unit is supposed to deliver 6,500 day case operations a year.

However nobody appears to have asked whether patients themselves are not exercising "choice" and seeking to stay in the NHS.

In South Yorkshire, Partnership Health Group has been found to have carried out only three quarters of the 7,000 procedures paid for by the local NHS, and local PCTs have forked out £700,000 for operations that have not been performed.

On the up

THE BOOMING business of treating NHS-funded patients has not brought any decline in the fully-fledged private practice of the major hospital chains, where income is apparently still riding high.

Britain's largest private hospital company, General Healthcare has insisted that it has seen growth in both its self-pay and insured business.

Then Swedish-owned Capio, the fourth largest echoed the bullish message, even though Capio's main growth in the UK will flow from its £300m contract to deliver 95,000 NHS operations over the next five years.

Now BUPA has reported another year of bumper profits from its hospitals and insurance business.

BMI Healthcare has just opened a new 48-bed hospital right next to the new £375m PFI-funded Wallsgrave Hospital in Coventry – a significant expansion from the 9-bed private wing the company used to run in partnership with the NHS Trust.

So all the cuts and crisis are concentrated in the public sector, while the private fat cats laugh all the way to the bank.

Meet the family

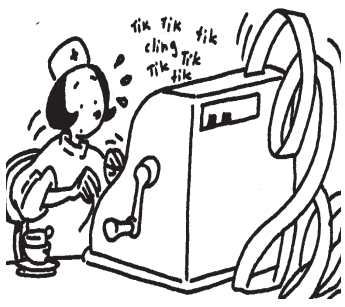
ON FEBRUARY 16 Tony Blair himself staged a formal "welcome" into the "NHS family" for eleven profit-hungry private companies.

The firms joining the new "NHS Partners network" are Alliance Medical, BUPA, Capio, Clinicenta, General Healthcare Group, Mercury Health; Nations Healthcare; Netcare; Nuffield; Partnerships Health Group (Care UK) and UK Specialist Hospitals.

Blair predicted that as many as 40% of operations in the private sector would soon be on NHS-funded patients.

Ministers have floated a target of 15% of NHS operations to be switched to private hospitals and treatment centres. However the impact of even this lower figure would be even larger than it appears because the private sector does not offer emergency treatment, and will not take on any potentially complex or costly cases.

So in some areas even the 15 percent figure would mean private providers creaming off a majority of routine surgical cases in some specialities: this would strike a body blow at the training of junior doctors, and at medical research which is only carried out in major NHS University hospitals.



Smithy's small claim to big job

THE NAME of Ian Smith has been thrown in to the ring as one of the possible contenders to succeed Nigel Crisp as chief executive of the NHS.

Who's he? Ian Smith is chief executive of Britain's largest private hospital chain, General Healthcare Group: but is this relevant experience? As such, Ian Smith presides over an empire comprising just 49 hospitals – all of them extremely small: in total General Healthcare has just 2,463 beds – an average of just 50 per hospital – equivalent to just three NHS DGHs.

Its turnover is just £545m a year compared to £80 billion for the NHS. Its workforce figures are not available, but are likely to be well short of the 1.3 million NHS employees.

And as a cherry-picking private company, General Healthcare never has to deal with the emergencies and complexities that are routine to even the smallest DGH.

Meanwhile it is worth noting the abject failure of the first private company to take over the management of an NHS Trust – at Good Hope Hospital in Sutton Coldfield.

Secta won a 3-year contract to manage the financially-challenged 550-bed Good Hope Hospital Trust in August of 2003, but were eased out 8 months early as the deficits spiralled even further out of control

The company successfully jacked up its own fees by 48 percent in its first year, but by the time the Trust's acting Chief Executive, Secta's Anne Heast, finally cleared her desk the Trust was piling on deficits at £1 million per month, leaving a total shortfall of £47m to be recouped by March 2007.

Quangos reorganised to drive privatisation and market reforms

MINISTERS have now nodded through proposals for the mergers of Strategic Health Authorities across much of England, and the accompanying proposals to merge many of the existing PCTs to form county-wide or rural plus urban PCTs.

The 'consultation' process on these latest changes was as ever a farce: the documents were desperately lacking in detail, ignoring the underlying context and framework within which this latest reorganisation of the NHS is taking place.

In fact the process towards mergers of PCTs is being driven by an accelerating national drive towards the fragmentation, privatisation and marketisation of our NHS.

The letter from the former NHS Chief Executive Sir Nigel Crisp which served as the introduction to each of the documents, flows from his controversial circular to all NHS managers last July – 'Commissioning a Patient Led NHS' – which pressed for the separation of PCTs' commissioning role from their direct provision of services.

Sir Nigel's call for PCTs to divest themselves of their directly provided services left (and still leaves) unanswered the question of who should take over these services.

With over 250,000 staff working for PCTs, the majority of them in directly-provided services, the issue is an urgent and worrying one.

When Crisp himself, right up to the point of his enforced "early retirement" falied to clarify or reassure angry Labour MPs, ministers stepped in to insist that there was no actual instruction for all PCTs to divest themselves of all services immediately.

The Commons Health Committee, in a hard hitting report last December expressed itself "appalled" at the lack of clarity over the future of services provided by PCTs, and unconvinced by ministerial assurances.

Even further from accountability: still the elected Greater London Assemby lacks any powers over health in London: over £10 billion in commissioning budgets is now to be controlled by a single quango

The MPs concluded that

"As far as we can see the overall direction of travel in fact remains unchanged, and PCTs will ultimately divest themselves of provider services".

Making no secret of her agenda, and defending the line of privatisation, Health Secretary Patricia Hewitt went as far as to claim at a press briefing in February that PCT staff were eager to be privatised, and that "there was 'widespread enthusiasm' from staff to move out of the NHS and work for the social enterprises invited to bid for primary care provision.

However there is no evidence at all of any such enthusiasm. NHS staff know that market-based health care cannot deliver a comprehensive health service, address issues of equity and health inequalities, or improve the quality of care.

It is this underlying background of marketisation and fragmentation that makes it impossible to endorse the proposed reorganisation of SHAs and PCTs.

The NHS needs some form of mechanism to make local services accountable to local people, and while the existing PCTs and SHAs are far from perfect in this regard, the new, larger, and more remote PCTs threaten to make matters even worse, while offering no compensating improvements, and no mechanism to hold the new bodies to account.

Fewer, larger, and less accountable SHAs and PCTs will be more vulnerable to future pressures from above to privatise, hive off or close down services.

Even during the consultation process itself steps were taken towards the privatisation of GP services in Derbyshire – with rumours in the medical press that ministers want up to 15 percent of GP practices to be hived off in similar fashion to private companies such as United Health Europe or for-profit groups of GPs.

Crisp's July 28 circular gave the SHAs less than 3 months to submit proposals – which would then be vetted by the Department of Health, and then put out to "consultation".

The changes to PCT boundaries were to apply from October this year (2006): SHA boundary changes from April 2007, and the separation of all services to be completed by April 2008.

This is no local policy tailored to local needs, but a rigid, national blueprint, driven from the top downwards, regardless of patient choice.

BOOKSHELF

Who has pocketed all the cash?

The political economy of health care: A clinical perspective by Julian Tudor Hart is published by The Policy Press at £14.99 www.policypress.org.uk

Although government has almost trebled expenditure on the NHS, about one third of NHS trusts are now deeply in debt, with many units threatened with closure and job cuts being announced across the country.

Where did the money go? Recent reports have suggested the immediate answer is staff wages, but in his new book, *The Political Economy of Health Care: A clinical perspective*, Dr Julian Tudor Hart offers a less comfortable explanation.

He argues that the policies of first Conservative, then New Labour, governments are transforming the NHS from a public service funded almost entirely from taxation and providing care through its own staff and buildings, into a management agency commissioning care through competing contractors investing for profit.

Dr Hart goes on:

"Though it is true that weekly wages for many lowest-paid staff are at last reaching the cost of one meal at a fashionable London restaurant, most of the new money has gone into the pockets of a generation of commercial, political, and professional predators, intoxicated by the trading potential opportunities opened by remaking health gain into the ultimate commodity.

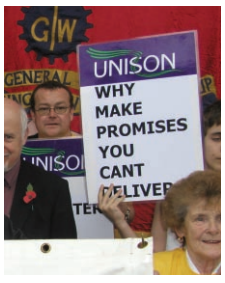
"Cost-effective health care depends on continuity and trust, elements which begin to disappear wherever business penetrate clinical decisions."

Julian Tudor Hart was a GP in the Welsh mining village of Glyncorrwg for 30 years, where his epidemiological research and innovative organisation of community care won him an international reputation. He is a past President of the Socialist Health Association, and an active supporter of today's Keep Our NHS Public campaign.

For those who support the principle of universal, equitable access to cost-effective health care, this quirky, radical vision of what is needed will replenish the armoury and come as a breath of fresh air.

HEALTH EMERGENCY

Step up fight against hospital closures!



Suffolk campaigners have just been rebuffed by Blair and Hewitt

Patricia Hewitt has openly admitted that her plans for NHS reforms mean "difficult decisions" to close down popular and busy local hospitals.

Large sections of England face the threat of cuts or closures in hospital services, ranging from large urban areas to sparsely populated rural towns and villages where the alternative to a local hospital is a long hard journey to a city.

80 community hospitals are under threat, despite the weasel words in Patricia Hewitt's White paper on community health services suggesting that closures should not be driven by short-term cash pressures, and campaigners have staged a lobby of parliament in addition to a succession of powerful protests around the country.

Among the areas where district general hospital services are known to be in the frame for possible closure plans are Surrey and Sussex, West London, South West London, Kent, Hampshire, Wiltshire, Bedfordshire & Hertfordshire, Nottingham, Yorkshire and Lancashire.

Tony Blair has promised to back managers who defy local public opinion, ignore patient choice, and opt to "reconfigure" hospital services with fewer beds and fewer buildings.

But in many areas powerful local campaigns have sprung up to resist closure plans, and this has proved the most effective means of pressurising ministers – with the threat of one, two, many Kidderminsters, after the victory there of council and parliamentary candidates opposing the closure of in-patient services at Kidderminster Hospital.

But Hewitt and Blair are well aware that the next general election may be four more years away, and they are hoping to force through painful changes now in the hopes that memories will have faded by the next polling day.

With local feelings running high, and blinkered Primary Care Trusts ignoring local views as they prepare to force through closures, it may well be time to revive the policy that helped to focus campaigns in the late 1970s and early 1980s – the 'work-in' occupation of threatened hospitals by staff supported by local campaigners.

The work-in allows professional staff to continue delivering care to patients and protects the threatened building: when all other avenues have failed, it may be the final throw of the dice.

For those wanting more information a reprint of the LHE pamphlet "Occupy and Win" can be found on our website *www.healthemergency.org.uk.*

Oxfordshire campaigners have always highlighted mental health services

Mental health hit by cuts

AS the cash crisis has tightened on Primary Care Trusts, the cuts have tended to land on those services not designated as priorities – and this means mental health.

Across the country short-term, cash-driven cuts have been proposed which undermine the ability of people with mental health problems to live with support in the community.

In January the Mental Health Act Commission warned that services were vulnerable to cuts as a result of cash pressures on PCTs, and that mental health wards faced severe pressure on beds and problems of understaffing.

In Norfolk finance pressures facing PCTs have meant that the Norfolk and Waveney Mental Health Partnership, which underspent in 2005-6, faces a £5m cut in resources for 2006-7.

But one good result from this has been the emergence of public campaigns to defend mental health services – with especially high profile campaigns led by UNISON in Cambridge, in Suffolk and Oxfordshire.

In Barnet in North London campaigners have fought back against the closure of the local psychiatric unit.

■ Meanwhile after eight years of angry protests, drafts and redrafts the government's controversial mental Health Bill has finally been abandoned.

Campaigners had condemned its proposals for compulsory treatment orders even for people who had not previously been detained, and its attempt to detain people with personality disorder even if they had committed no offence and their condition was untreatable.

Ministers will now seek to amend existing legislation.

The Mental Health Alliance which has emerged to spearhead the campaign has united service users, health unions and professionals.

It has pledged to continue to ensure that the eventual legislation respects civil rights and protects the public.

A message to all LHE affiliates

The campaign goes on!

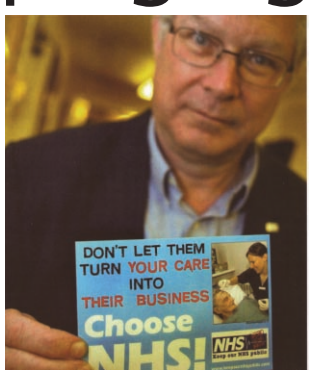
THIS is the first issue of *Health Emergency* since last summer, and we apologise to affiliates and readers for the long delay.

LHE has been active throughout the intervening months, working with other campaigners, trade union activists, academics and doctors to launch and sustain the Keep Our NHS Public campaign, including the establishment of its website and publicity materials.

LHE's John Lister has spoken at a large number of Keep Our NHS Public events around the country, and also worked closely with UNISON branches and regions on a number of specific campaigning issues.

These include work with UNISON Eastern Region on a report and campaign newspaper challenging the cuts and closures in East Anglia; a detailed report exposing the background to the cash crisis at University Hospital of North Staffordshire Trust in Stoke; a response for UNISON Northern Region to a small PFI project for a new Northern Neuro Disability Services Centre in Newcastle; a response challenging the plans to close Goscote Hospital in Walsall; a response to the "consultation" process on the PFI hospital scheme in Wakefield and Pontefract; and responses for UNISON East Midlands and West Midlands regions to the plans to merge SHAs and PCT. All this has been in addition to newspapers and publicity work for a number of local UNISON branches.

As the pace of change has increased, LHE in the last four months has maintained the research and monitoring function, but also stepped up LHE's media profile, and are now issuing regular and frequent press releases. LHE is again established as a reliable source of critical media comment both in London and around the country.



John Lister brandishes Keep our NHS Public postcard for Health Service Journal photographer outside meeting to launch campaign against privatisation of GP services in Langwith and Cresswell, North Derbyshire

New international links have also been established, with contacts from trade unions and campaigners in Canada and various European countries.

With so many complex policy issues to respond to in this edition of *Health Emergency*, we have not been able to convey the full flavour of the campaigning activity that is beginning to develop.

After 22 years of *Health Emergency*, we still have work to do.

So we hope that all those branches already affiliated will want to keep in contact with LHE, and may even want to commission LHE's publicity and research services for a report or a newspaper that you might otherwise not be able to produce – and that new readers and supporters will want to affiliate and get in touch.

Join us, and work with us to build the broadest possible campaign to defend the principles of the NHS, jobs and local services.

Join Keep Our NHS Public

NHS NOT FOR SALE Keep our NHS public

● Annual membership £10/£5 waged/unwaged.
● Trade union affiliations: £30
● Local health and anti-cuts campaigns £20
● Pensioners groups £15
● Regional organisations £100 ● National organisations £250

I want to join/affiliate our organisation to Keep Our NHS Public. I enclose a membership fee of £..... plus a donation of £..... Cheque total £..... (payable to Keep Our NHS Public)
[delete as appropriate]

Name .....

Address for mailings .....

..... Postcode .....

Phone ..... Email .....

Organisation (if any) .....

Position held .....

Send completed form to us at: Keep Our NHS Public, c/o NHS Support Federation office, Community Base, 113 Queens Road , Brighton, BN1 3XG

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